RONALD FANTOZZI

5 OF 18

St. Mary's Regional Medical Center
Procedure Record

??????? JD 221342
ADM 6/07/99
???????, RONALD M M
?? POLAND RD
? ME 04210
???????35?21-01
DOB [redacted]/62 7823873

Date: 6-7-99

Physician: [illegible]

Pertinent Physical Findings:

Pre Procedure Evaluation:

Dictated Note: ✓ COLONOSCOPY

Procedure: [illegible]

Findings:

[illegible]

① [illegible]

② [illegible]

Remaining colon [illegible]

Plan of Care: [illegible]

[illegible]

[illegible]

[signature]

Physician's Signature

MR 221342

St. Mary's Regional Medical Center

Consent/Assignment/Authorization Statement

[redacted] Admission Date: 6-2-99

I, the undersigned a patient in this St. Mary's Regional Medical Center ("SMRMC"), hereby authorize employees of SMRMC and physicians (and whomever they may designate as assistants) to administer such treatment as is necessary, and such additional operations or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment. I also consent to the adminstration of such anesthetics as are necessary. Any tissues or parts surgically removed may be disposed of by SMRMC in accordance with accustomed practice. I hereby certify that I have read and fully understand the above Consent for Treatment, the reasons why the treatment/procedure is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment which have been explained to me by the attending physician. I also certify that no guarantee or assurance has been made to the results that may be obtained.

[redacted]

St. Mary's Regional Medical Center is hereby authorized and requested to furnish the BC/BS insurance company(s) or its properly authorized agent, my employer and any peer review organization which conducts reviews of hospital utilization under an agreement with my employer and/or health insurance carrier, or any person or corporation that is or may be liable, under contract or otherwise, for all or part of the Medical Center's charge; all information required by it to determine benefits, including nature of the visit, diagnostic and treatment information, and copies of my medical record which may be available to said hospital.

[redacted]

I hereby assign unto St. Mary's Regional Medical Center and related contracted professionals, all hospital insurance benefits now due and to become due and payable to me or on my behalf, but not to exceed the Medical Center's charges by virtue of my treatment by the hospital, and I hereby direct the BC/BS Insurance Company(s) to pay such benefits directly to the hospital in consideration of the hospital care and services furnished and to be furnished by the hospital.

Payment Terms

I understand payment of charges are due for services rendered within Thirty (30) days including any collection or attorney's fees. If I am financially unable to do so, I agree to complete a detailed financial statement so alternative payment arrangements can be determined. I agree to pay all charges for services not authorized for payment by any Health Maintenance Organization, Preferred Provider Organization or other Managed Care Organization for which I seek certification for treatment by St. Mary's.

[redacted]

I understand and agree that under no circumstances will St. Mary's Regional Medical Center be responsible for my personal property. I take full responsibility for retaining in my possession or custody any and all articles. I acknowledge that I have declared or listed all items of personal property I have chosen to keep in my possession or custody while at St. Mary's, and further acknowledge that I have been offered an opportunity to have my personal property kept at St. Mary's during my stay at St. Mary's, and that I have refused that offer.

[redacted]

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or any other medical insurers, any information needed for this or a related Medicare, or other medical insurance claim. I request that payment of authorization of authorized benefits be made to St. Mary's Regional Medical Center and to physicians or organizations providing medical services to me or for my benefit. For extended outpatient services I request this authorization apply to the extent of my services.

[redacted]

I certify that I have received the Medicare Bill of Rights entitled "An Important Message From Medicare/Champus". Acknowledgement of receipt of this message does not waive any of my rights to request a review or make me liable for payment.

I Have Read This Consent/Authorization Completely And Crossed Out Any Words Or Phrases That I Do Not Accept:

Patient Signature: [signature] Date: 6-2-99 Time: 1430

Guarantor Signature [signature] Date: 6-2-99 Relationship

Witness Signature [signature] Date

Telephone Consent Received By: _____ Date: _____ Time: _____

500685.011.0091

[redacted] Pontantozzi [redacted]

915[redacted] DD HR [redacted] 221342
ADM 6/07/99
PANTOZZI, RONALD M M
47 POLAND RD
[redacted] ME 04210
ME[redacted]-01
DOB [redacted]/02 7823873

St. Mary's Regional Medical Center

Multidisciplinary Assessment

Date 6-7-99 Physician Mongel Primary Care Physician Boulanger
Diag./Chief Comp. hx crohns d
Allergies NKA Latex Food
Environmental Drugs/Reaction:

Current Medications: Name, Dosage Last Dose

oxycontin 40mg BID
Prednisone 20mg QD
Unaria
anxiety pill

Past History:

Y/N Alcohol
Y/N Anemia
Y/N Arthritis
Y/N Back problems
Y/N Blood thinners
Y/N Bleeding problems
Y/N Bowel disease crohns d
Y/N Cancer
Y/N Chemo/Radiation therapy
Y/N Cortisone/Steroid use Prednisone
Y/N CVA/stroke
Y/N Drug Use
Y/N Diabetes
Y/N Epilepsy/Seizures
Y/N Emotional disorder anxiety/panic attacks
Y/N Gallbladder disease hx
Y/N Fainting spells/syncope anxiety caused
Y/N Heart disease
Y/N Heart murmer
Y/N Hepatitis/jaundice type C
Y/N Hypo/ Hypertension
Y/N Kidney/bladder disease stones (multiple)
Y/N Liver disease
Y/N Lung disease chronic bronchitis
Y/N Smoker ppd/ Cough
Y/N Neurological disease
Y/N Pregnant LMP
Y/N Thyroid disease
Y/N TB exposure
Y/N Ulcer disease
Y/N Other

Past Surgery: appendectomy
colon resection cholecystectomy

Pre-admission assessment signature: [redacted]

Mental status	Skin condition	Mobility	Prostheses
✓ Alert	✓ WNL	✓ Ambulatory	Dentures
Oriented		Assisted amb.	Glasses
Confused		Wheelchair	Hearing Aide
		Stretcher	Walker/Cane
Prep	NPO since	Pre procedure teaching done	
Home		Person to notify at discharge	
Hospital	ASA Class		
Enemas	1-2-3-4-5	Telephone #	

Time T 37.1 P 96 R 20 Bp 116/82 Ht 5'6" Wt [redacted] O2 Sat
Admission assessment signature:
Breath sounds: Rt Lt Not auscultated
Heart sounds: Not auscultated
Abdomen: Not palpated
Comments: NEEDS DIPROVAN
Reviewed by Physician:

500685.011.0092

ST. MARY'S REGIONAL MEDICAL CENTER

Lewiston, ME 04240

9155771 22-13-42

FANTOZZI, RONALD M
DOB: [redacted]1962

PROCEDURE NOTE

INPATIENT_____ OUTPATIENT __xx__ DATE: 06/07/99

PHYSICIAN: MICHAEL MONZEL, M.D.

PROCEDURE: Colonoscopy

INDICATIONS: This 37 year-old male, with known Crohn's disease, had an anastomotic stricture identified last fall. He represents for assessment, as he has an intractable pain despite aggressive management with azathioprine and prednisone. On examination, he is well nourished. Abdomen is nonspecifically tender diffusely, especially on the right.

ANESTHESIA: Per anesthesiology, as he was given a general anesthetic due to his poor response to conscious sedation in the past.

INSTRUMENT: Olympus CIF 100 videoendoscope

FINDINGS: Digital examination revealed no mass in the rectum. The endoscope passed by the anal canal into the rectum and under direct visualization, it was advanced easily into the left colon, across into the transverse colon, into the ileocolonic anastomosis. The ileocolonic anastomosis was angulated but with maneuvering of the patient and the scope, the endoscope was able to pass well into the neo-terminal ileum and extended for 20 cm. The anastomosis itself was very patent and free of any active inflammatory changes. Biopsies were taken to assess for indolent Crohn's. The remaining right colon, transverse, descending, sigmoid colon, and rectum were entirely normal. A retroverted turn revealed no pathology.

IMPRESSIONS:

1. Previous right hemicolectomy and ileal resection with normal and patent appearing ileocolonic anastomosis

The current examination offers no suggested evidence of active ongoing Crohn's. The etiology of the pain remains unclear and may be related to other factors other than his Crohn's.

(SEE NEXT SHEET)

PLAN: Taper prednisone further. Continue current dose of Imuran. Will follow.

MICHAEL MONZEL, M.D.

D: 06/07/99 MM
T: 06/09/99 sb

cc: MICHAEL MONZEL, M.D. (F)
MICHAEL BOULANGER, M.D. (F)
RONALD SNYDER, M.D. (F)
DEPT2 (F)

St Mary's Regional Medical Center
Department of Pathology

Final Pathology Report

Patient Name	**Fantozzi, Ronald**	Surgical #:	S-99-2107
Date of Birth:	[redacted]62	Date Received:	06/07/99
Account Nbr:	9155771	Date Reported:	06/08/99
Med Rec Nbr:	221342		
Location:	OPD	Document ID:	25678A00441CC7
Physician:	Monzel	Copies To:	

Specimens:
Biopsy ileocolonic anastomosis

Gross Examination:
The specimen consists of two 4 mm fragments of pink mucosa which are entirely submitted.

Microscopic Examination:
Sections show unremarkable fragments of colonic mucosa. No tumor or inflammation are seen.

Diagnosis:
Fragments of colonic mucosa from the ileocolonic anastomosis site.

Codes:

Alan R. Solander, M.D., Pathologist

S-99-2107 Fantozzi, Ronald

Rev. 7/90

ST. MARY'S REGIONAL MEDICAL CENTER
ANESTHESIA RECORD

ADM 6/07/99 MR [redacted]
FANTOZZI, RONALD M M
43 POLAND RD
AUBURN ME 04210
MIN000606005921-01
DOB [redacted]62 7823873

SURGEON: M Menzel	ANESTH. NO. 1 (2) 3 4 5 E
PROCEDURE: Colonoscopy + Biopsy	PERMIT Yes/No
(M) F 37 AGE HT. 56 WGT. 196	DATE 6/7/99
TECHNIQUE: ☐ GA ☐ REG. ☐ SPI. ☐ EPID. ☐ MAC	SHEET OF
ALLERGIES:	Hct.

PREMED:

DRUGS
- N2O/O2 — nasal O2 — 4 l/min
- Fentanyl
- Propofol 50 50 30 30 — 180 mg

INFUSIONS
- NS

MONITORS
- EKG: SR
- FIO2
- SaO2: 99 98 95
- ETCO2
- V/RR
- PIP/PEEP
- TEMP
- SvO2/c.o.
- PAP/PCWP/CVP
- PNS
- TIME: 1130 — 1145

TOTALS	ANESTHESIA TIME 1130 /
	SURGICAL TIME /

MACHINE # ____ EQUIP. CHECKED PRE-OP ☑

INTRA-OP EVENTS:
Medication
MC2
iv Fentanyl 200 µg
iv Propofol 180 mg
awake alert and well

MONITORS ☐ EKG ☐ PCS ☐ ES ☐ FIO2 ☐ SaO2 ☐ ETCO2 ☐ TEMP ☐ PNS

BP ☐ MANUAL ☐ NIBP ☐ A-LINE

OTHERS ☐ ☐ ☐ ☐ ☐

150 / 100 / 50

for events

KEY: ANES. x...x; OPER. ⊙...⊙; BP V Λ; A-LINE I; PULSE •; RESP { SPONT O, A ⊘, C ⊗ }

FLUID
- IV #1 (cc)
- IV #2 (cc)
- NS
- EBL (cc)
- URINE (cc)
- POSITION

TOTALS

AIRWAY
☐ MASK ☐ OPA ☐ NPA
☐ ETT SIZE ___ ☐ CUFF
☐ OR ☐ NAS ☐ TRACH
☐ DIR ☐ BLIND ☐ FIBER
TIME INT/EXT ___ / ___
BLADE ______ #ATT ______
☐ BREATH SOUNDS EQUAL

VENTILATION/MISC.
CIRCUIT ____ VENT TYPE ____
☐ HUMID ☐ HME ☐ BLD. WARMER
EYES: ☐ LUBE ☐ TAPE ☐ PADS

CATHETERS	TYPE	SIZE	SITE	DT
1				
2				
3				
4				

ARRIVAL PACU DATE 6/7/99 TIME 1200
B/P 120/70 PULSE 76 RESP. 14
REMARKS: awake back to care room

SIGNATURE

ANESTHETIST

ATTENDING SIGNATURE [signature]

500685.011.0096

[redacted] 221342
[redacted] D M M
[redacted] ME 04210
[redacted]-01
DOB [redacted]92 7823873

St. Mary's Regional Medical Center

Permission For Special Procedures - Outpatient

I authorize the performance of a colonoscopy with possible biopsy and/or polypectomy procedure on myself (Name) performed by or under the direction of Dr. Mongel (Name of Physician)

The nature and purpose of the procedure, possible alternative methods of treatment, the risks involved, the possible consequences and the possibility of complications have been explained to me by Dr. Mongel (Name of Physician).

I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.

Date: 6-2-99
Time: 1430

Kevin Martin RN (Witness)

Ronald Johnson (Signature of patient or guardian or medical power of attorney)

I certify that the nature and purpose of the procedure, including the possibility of complications have been explained to the patient.

(Signature of physician)

[redacted]OUTPATIENT[redacted]

500685.011.0097

St. Mary's Regional Medical Center
Endoscopy Flow Sheet

[redacted] MR 221342
ADM 6/07/99
FANIOZZI, RONALD M M
[redacted] POLAND RD
[redacted] ME 04210
MRN0000572?-01
DOB [redacted]62 7823873

Date 6-7-99 Procedure Colonoscopy
Diagnosis hx Colitis Physician Mongelli
Allergies
I.V. Therapy Soln 500 N/S Needle #angio
Site L arm Time 0950 Rate KVO
Attempts #1 Signature D Bellmore
Time arrived in procedure room 1135
X Pt. identified by arm band
X Verbal verification of procedure with patient
X Stretcher locked / Side rails up
X Consent signed
Scope CF-Y2L #1 Start Time 1143

X Cardiac Monitor
X Oximeter
X NIBP

Int.	Signature	Int.	Signature
VH	D Bellmore		

Time	Medications	Dosage	O2 Sat	Patient Response	Int
0955	Reglan	10 mg			HS
1143	Fentanyl	200 mcg IV		given by Dr Mongelli - See Anesthesia Record	VH
1155	Diprivan	180 mg IV			VH

Assessment

Time	B/P	P	R	O2 Sat	Cardiac Rhythm	Comments	
1137	136/82	80	18	100%	NSR	WNL	HS
1142	125/79	95	20	99%	NSR	WNL	HS
1145	124/74	99	16	98%	NSR	WNL	HS
1148	125/70	86	16	99%	NSR	WNL	HS
1152	126/91	81	15	98%	NSR	WNL	HS
1157	115/67	79	16	97%	NSR	WNL	HS

X O2 Start Time 1140 D'cd ____ Liters 3 ½ L Via NC
☐ Cautery ☐ Bicap Cut ____ Coag ____ ☐ Pure ☐ Blend Pad # ____ Pad Site ____
☐ Dilators Type ____ Size ____ ☐ Sclerotherapy Procedure end time 1157

Specimens
3X - Hyperplastic
Adenoma's
Total # of Specimens to Lab 0

Patient Status Post Procedure
LOC ☐ Awake X Drowsy, arousable to verbal stimuli ☐ Drowsy, arousable to tactile stimuli
☐ Unresponsive/antagonistic given ____
☐ Combative ☐ Retching
Skin X Pink ☐ Pale ☐ Dusky ☐ Cyanotic X Warm
X Cool X Dry ☐ Diaphoretic
Respirations X Regular ☐ Shallow ☐ Labored
Transferred to Recovery Room Time ____

Assistant S MASTERS (CT) Circulator D Bellmore

Post Procedure Flow Sheet

9155771 OD MR 221342
A[redacted] 9/07/99
[redacted]721, RONALD M M
43 [redacted] RD
A[redacted] ME 04210
M[redacted]-01
DOB [redacted]62 7823873

Level of Consciousness: 2 = fully awake; 1 = drowsy, but oriented; 0 = very sleepy
Color: 2 = pre procedure color; 1 = pale; 0 = very pale, dusky
Respirations: 2 = deep, easy spontaneous; 1 = respirations adequate; deep when encouraged; 0 = respirations shallow dyspneic
Bleeding: 2 = no signs of bleeding; 1 = slight bleeding, small amount; 0 = large amount of bleeding
Nausea and Vomiting: 2 = no nausea; 1 = some nausea; 0 = nausea and vomiting
Pain: 2 = no pain; 1 = minimal pain; 0 = excessive pain
Activity: 2 = ambulates steadily; 1 = ambulates with assistance; 0 = bedrest
Diet: 2 = tolerates p.o. fluids well; 1 = has not taken p.o. fluids; 0 = unable to take fluids
Abdomen: 2 = soft, undistended; 1 = soft, distended; 0 = firm, distended
Esophagus: 2 = swallowing without difficulty; 1 = Swallowing with difficulty; 0 = unable to swallow

Vital Signs				Nursing Assessment											
Time	BP	P	R	Loc	Color	Resp	Bld.	N/V	Pain	Act.	E/A	Diet	O2 Sat	O2 LPM	IV Rate	Int.
1200	110/66	83	18	1	2	2	2	2	2	0	2	1	98	2	KVO	KVO
1215	100/70	73	18	1	2	2	2	2	2	0	2	1	96	RA	KVO	KVO
1235	110/60	75	18	2	2	2	2	2	2	0	2	1	96	RA	KVO	KVO
1250	100/70	75		2	2	2	2	2	2	0	2	1	97	RA	KVO	KVO
1305																

☑ IV d/c'd at 1315 Volume infused 250 ml ☑ No redness or swelling at IV site

Patient Problems	Interventions	Evaluation

Comments

Discharge Summary (circle one) 2 = meets all criteria satisfactorily.
1 = fails to meet all criteria: discharge by doctor with special instruction.

0 = continued skilled observation required: patient admitted to hospital. Room Number _____
Report given to _____

Discharge Time 1330
Discharge to ☑ home ☐ relatives home
☐ other _____
Via ☐ ambulatory ☑ wc ☐ other
accompanied by ☑ spouse ☐ relatives ☐ friend
☐ other _____

☑ Instructions to patient/family
☑ Patient/family verbalized understanding of instructions
☑ Discharged with belongings
☑ Doctor spoke to patient before discharge

Patient teaching aids given to patient
☐ Pamphlet, Informational Sheets
☐ Dressing change equipment
☐ Prescription
☐ Other

Init	Signature	Init	Signature
[redacted]	[redacted]	[redacted]	[redacted]

Physician's Orders

Name: _____

9155771 00 MR 221342
A[redacted] 6/07/99
FANTOZZI, DONALD M M
43 OAKLAND RD
[redacted] ME 04210
[redacted]-01

Date Started	Date Discontinued	OPD - Pre Endoscopy Orders Dr. O'Connor, Dr. Monzel, Dr. Sivulich, Dr. Lewandowski	Signature
6-7-99		1. For patients having a colonoscopy (Yes) / No a) start colyte 8oz q 5-10 min until returns are clear Yes / (No) b) give tap H2O enemas until returns are clear	
		2. Start an IV - NS - KVO rate.	
		3. Reglan 10mg IV for nausea/vomiting (circle (YES) or NO).	
		4. (Circle YES or NO) Titrate Premeds	
		YES (NO) a) Stadol 0.5 mg - 1.0mg IV	
		YES (NO) b) Demerol 25 mg - 50mg IV	
		(YES) NO c) Fentanyl 25mcg - 50mcg IV may repeat dose x1	
		YES (NO) d) Droperidol 0.625 mg - 1.25 mg - 2.5mg IV	
		YES (NO) e) Benadryl 50mg IV	
		5. O2 at 2 liters prn to maintain O2 saturation over 90%.	
		6. Versed 0.5 mg - 1.0 mg IVP q 2 mins up to 10 mg intraprocedure for sedation	
		Post Endoscopy Orders Noted by [signature]	
		1. Blood pressure, pulse and respiration.	
		q 15 min x 2 - if stable	
		q 1/2 hr x 2 - if stable	
		q 1 hr x 2 - if stable	
		2. Narcan 0.2mg - 0.4mg IV per nursing assessment if Fentanyl/ Stadol/Demerol was given for a premedication.	
		3. NPO until gag reflex returns.	
		4. May be discharged in 1 - 1 1/2 hours post procedure if stable or as ordered by the physician.	
		5. Trilafon 5mg IM if needed for nausea and/or vomiting.	
		6. Rectal tube prn if unable to pass flatus.	

Med. Dept. Approved: 3/9/93 [signature]

500685.011.0100

St. Mary's [redacted] gional Medi[redacted] Center

9155724 OD HR 221342
ADM [redacted] 7/99
FANTOZZI, RONALD M M
43 POLAND RD
AUBURN ME 04210
MIN0066035721-01
DOB [redacted]62 7823873

Outpatient Department Discharge Instructions

You have undergone a procedure called: ____ Gastroscopy ____ Colonoscopy ____ Bronchoscopy ____ ERCP ____ Minor Surgery _____

1. You must have someone drive you home if you have received sedation. You cannot drive and you should have someone stay with you the remainder of the day. **Do Not: Drive a car, operate machinery, make any important decisions, or drink alcohol.**

2. Limit your activities for today. Go home and rest. The effects of the medications should wear off by the next day and you will be able to resume your normal activities.

3. Diet: Eat a light diet (soups, jello, ect.) / soft diet and advance gradually today to your normal diet unless otherwise instructed by your doctor. Drink plenty of fluids.

4. You may resume your normal prescription medicines, unless otherwise instructed by your doctor.

5. There may be some soreness where the instruments have been, this will wear off in a day or two.

6. Some bloating may be experienced if air has been retained in your gastrointestinal tract (stomach and/or bowel) this will pass as you expel the air.

7. Call Dr. Monzel at 774-5284 if you have any questions or any of the following problems:
   - Excessive pain, nausea/vomiting
   - Signs of any excessive bleeding
   - Redness, tenderness, and swelling at the IV site that persists for more than 48 hours
   - Temperature greater than 101 not related to a cold or flu

8. Your doctor will notify you about the results of any biopsies. If you have not been notified within a week with the results, contact your doctor.

9. If a biopsy or a polypectomy has been done, blood thinners, ASA or any products containing ASA should be avoided for one week.

Patient/Accompanying Adult: Ronald Fantozzi Time: _____

Instructions Reviewed By: _____

Office Appointment with Dr. _____

Date: _____ Time: _____

Dr Monzel will call with results -
"Continue all current meds
Reduce prednisone to 5mg

Reviewed and given to patient by: [redacted]

500685.011.0101

[redacted] EMERGENCY DEPARTMENT REPORT

St. Mary's REGIONAL MEDICAL CENTER

ADMIT NO	FC	HOW ARRIVED	MED REC NO	PATIENT NAME	SERVICE	NUR STA	ROOM - BED	
9073575	1	W	00221342	FANTOZZI, RONALD M	EME		3/14/99	23:19

PATIENT ADDRESS	AGE	DATE OF BIRTH	PLACE OF BIRTH	SEX	MAR. STATUS
40 POLAND RD	036Y	[redacted]62	CT	M	M

CITY, STATE, ZIP	MAIDEN NAME	MOTHER/FATHER NAME
AUBURN ME04210		

PMD CALLED
PMD RESPONDED
TX
RELEASED

CONDITION AT DISCHARGE: EXCELLENT, GOOD, FAIR, CRITICAL, WALKED, CRUTCHES, WHEELCHAIR, STRETCHER, CARRIED

ADMITTED
TREATED & RELEASED
REFERRED TO:
DR.

ATTENDING PHYSICIAN	NEXT OF KIN/SPOUSE	NAME AT LAST ADMIT	VETERAN
WOOD, DOUGLAS R.	DEBORAH		

PRIVATE PHYSICIAN	RACE/ORIGIN	RELIGION	PREV. DISCH. DATE	EMS. NO.
BOULANGER, MICHAEL J	C	01		

DATE AND TIME OF SERVICE	ACCIDENT DATE/HOUR	DATE AND TIME OF DEATH
3/14/99 23:12	3/14/99 18:00	

BLUE CROSS OF ME	POLICY NO.	GROUP NUMBER	SUBSCRIBER'S NAME(S)	RELAT
	MTN006605921-		FANTOZZI, RONALD M	PT

PT PHONE #	NEXT OF KIN PHONE #	SOC. SEC. #
207 782-3873	207 782-3873	000542224

PRESENTING COMPLAINT: SEVERE LEFT FOREARM/HAND PAIN

DIAGNOSIS

ALLERGIES	LAST TETANUS

TRIAGE

TRIAGE SIGNATURE

		PPD		

MEDICATIONS:

- ☐ CBC
- ☐ LYTES
- ☐ BUN
- ☐ BS
- ☐ AMYLASE
- ☐ ETOH
- ☐ CCU SPEC
- ☐ CDAG
- ☐ UA
- ☐ CS
- ☐ SS
- ☐ RED TOP HOLD
- ☐ SMA 12
- ☐ EKG
- ☐ ABG
- ☐ HCG
- ☐ X-RAY
- ☐
- ☐
- ☐
- ☐

RX/PROCEDURE

DISCHARGE DISPOSITION

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
DATE	TIME				

500685.011.0102

☐ PATIENT CALLED WITH LABORATORY / X-RAY RESULTS: _____ DATE _____ TIME _____ INITIALS

St. Mary's Regional Medical Center
Consent/Assignment/Authorization Statement

Consent for Treatment Admission Date: _____

I, the undersigned a patient in this St. Mary's Regional Medical Center ("SMRMC"), hereby authorize employees of SMRMC and physicians(s) (and whomever they may designate as assistants) to administer such treatment as is necessary, and such additional operations or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment. I also consent to the adminstration of such anesthetics as are necessary. Any tissues or parts surgically removed may be disposed of by SMRMC in accordance with accustomed practice. I hereby certify that I have read and fully understand the above Consent for Treatment, the reasons why the treatment/procedure is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment which may have been explained to me by the attending physician. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Authorization To Release Medical Information

St. Mary's Regional Medical Center is hereby authorized and requested to furnish the _____ insurance company(s) or its properly authorized agent, my employer and any peer review organization which conducts reviews of hospital utilization under an agreement with my employer and/or health insurance carrier, or any person or corporation that is or may be liable, under contract or otherwise, for all or part of the Medical Center's charge; all information required by it to determine benefits, including nature of the visit, diagnostic and treatment information, and copies of my medical record which may be available to said hospital.

Assignment Of Benefits

I hereby assign unto St. Mary's Regional Medical Center and related contracted professionals, all hospital insurance benefits now due and to become due and payable to me or on my behalf, but not to exceed the Medical Center's charges by virtue of my treatment by the hospital, and I hereby direct the _____ Insurance Company(s) to pay such benefits directly to the hospital in consideration of the hospital care and services furnished and to be furnished by the hospital.

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Release From Responsibility For Personal Property

I understand and agree that under no circumstances will St. Mary's Regional medical Center be responsible for personal property. I take full responsibility for retaining in my possession or custody any and all such articles.

Authorization For Payment Of Medical Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or any other medical insurers, any information needed for this or a related Medicare, or other medical insurance claim. I request that payment of authorization of authorized benefits be made to St. Mary's Regional Medical Center and to physicians or other persons providing medical services to me or for my benefit. For extended outpatient services I request this authorization apply to the dates of my services.

Medicare Bill of Rights Statement

I certify that I have received the Medicare Bill of Rights entitled "An Important Message From Medicare/Champus". Acknowledgement of receipt of this message does not waive any of my rights to request a review or make me liable for payment.

I Have Read This Consent/Authorization Completely And Crossed Out Any Words Of Phrases That I Do Not Accept

Patient Signature:	Date	Time
Witness Signature	Date	Time
Witness Signature	Date	Time
Signature of Parent/Guardian	Date	Time

St. Mary's Regional Medical Center
Campus Avenue PO Box 291
Lewiston, Maine 04243-0291
Page 3 of 3

9073575 MR 221342
ADM 3/14/99
[redacted]. RONALD M M
4[redacted] ISLAND RD
[redacted] ME 04210
ME 0006605921-01
DOB [redacted]62 7823073

For Inpatients only:

I certify that I have received the Medicare Bill of Rights entitled "An Important Message from Medicare/Champus". Acknowledgement of receipt of this message does not waive any of my rights to request a review or make me liable for payment.

Release from Responsibility for Personal Property

I understand and agree that under no circumstance will SMRMC be responsible for my personal property. I take full responsibility for retaining in my possession or custody any and all articles. I acknowledge that I have declared or listed all items of personal property I have chosen to keep in my possession or custody while at SMRMC, and further acknowledge that I have been offered an opportunity to have my personal property kept at SMRMC during this admission, and that I have refused that offer.

Consent

I have read this consent/authorization/assignment statement completely and have crossed out any words or phrases that I do not agree to.

3-14-99 Date
2313 Time
X Ronald A Tantorri Patient Signature
Print Name: Ronald Tantorri

If the patient is a minor or without capacity:
Time
Parent/Legal Guardian
Print Name:

3-14-99 Date
2313 Time
Witness Signature
Print Name:

Patient unable to sign for the following reason:

Telephone Consent received by:
Name:

Date: Time:

500685.011.0104

St. Mary's Regional Medical Center
Campus Avenue PO Box 291
Lewiston, Maine 04243-0191
Page 2 of 3

Emergency Department

[redacted]
AUN [redacted]/99
[redacted] RONALD H H
[redacted] ROLAND RD
[redacted] ME 04210
MINC06605921-01

DOB [redacted]62 7823873

Authorization to Release Medical Information for Payment & Assignment of Benefits

SMRMC is hereby authorized and requested to furnish to any person who is or may be responsible for the payment of the charges incurred for my treatment at SMRMC, including any insurance company, third party administrator, my employer, or any of the properly authorized agents or representatives, and any peer review organization which conducts reviews of hospital utilization under an agreement with my health insurance carrier, third party administrator, or employer, or any person that is or may be liable therefore under contract or otherwise: all information required by it or them to determine benefits, including the nature of the visit, diagnostic and treatment information, and copies of my medical record which may be available to SMRMC. SMRC can disclose information to the persons so authorized on a continuing basis for as long as the authorization remains in effect. This authorization will remain in effect for the term of my current insurance coverage, along with any applicable renewals of that coverage.

I understand that I can refuse to release medical information for the purposes above listed. I also understand that if I refuse to release this information my insurance company or other person liable to bear my hospital expenses may not cover my expenses while I am treated at SMRMC. I understand this authorization to release medical information may be revoked (cancelled) by me at any time. In order to revoke my consent, I must send a written notice to St. Mary's Regional Medical Center, Attention: Health Information Management Services, PO Box 291, Lewiston, Maine, 04243-0291. I understand that SMRMC may properly rely upon any authorization I have given to release medical information with respect to disclosure made before revocation of such authorization.

I understand payment of charges for medical care from SMRMC is due for services rendered within thirty (30) days of service, and I will be responsible for any fee incurred by SMRMC for collection of delinquent charges or attorney's fees incurred in the connection therewith. If I am financially unable to do so, I agree to complete a detailed financial statement so that alternative payment arrangements can be determined.

I certify that the information given by me in applying for payment by the Medicare or Medicaid programs or any managed care provider is correct. I request that payment of authorized benefits be made to SMRMC and to physicians or organizations providing medical services to me or for my benefit. For extended outpatient services, I request that this authorization apply to the extent of my services. If I receive medical services which are not covered by Medicare or Medicaid because those programs determine that the services are not medically necessary, I understand that I have the obligation to pay for those services. I agree to pay all charges for services not authorized for payment by any health maintenance organization, preferred provider organization or other managed care organization for which I seek certification for treatment by SMRMC.

I hereby assign to SMRMC and related contracted professional service providers all hospital or professional service insurance benefits now due or which may become due and payable to me or on behalf (but not to exceed the charges for such services) by virtue of my treatment at SMRMC, and I hereby direct any person including, but not limited to, an insurance company, third party administrator, my employer, preferred provider organization or other person responsible for payment of my medical care to pay such benefit directly to SMRMC in consideration of the care, treatment and services furnished or to be furnished by or through SMRMC.

Name of Insurance Company(s): Blue Cross (HMO)

Emergency Department

St. Mary's Regional Medical Center
Campus Avenue PO Box 291
Lewiston, Maine 04243-0291

Admission Date:_____

Authorization for Treatment

The undersigned patient at St. Mary's Regional Medical Center ("SMRMC") hereby authorizes SMRMC's physicians and employees (and whomever they may designate as assistants) to administer such medical treatment as necessary in their professional judgement. I further consent to the administration of such anesthetics as are necessary in connection with such treatment. Any tissues or parts surgically removed may be disposed of by SMRMC in accordance with its customary practice.
Further I realize that there are medical, nursing and other health care personnel who are in training and unless requested otherwise, they may participate in my care as part of their education. I hereby certify that I have read and fully understand the above Authorization for Treatment, the reasons why the treatment/procedure is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment which have been explained to me by the attending physician. I understand that no guarantee or assurance has been made to the results that may be obtained.

Limited Authorization to Release Medical Information

SMRMC is hereby authorized to provide information about my general condition and presence within the hospital in order to respond to questions, receive telephone calls, visitors, mail, gifts, and other deliveries. This includes confirmation of my presence in the hospital to the media, unless otherwise specified. General condition responses mean "good", "fair", "serious", "critical", or "undetermined". Information about my presence and condition, unless requested otherwise, may be shared with SMRMC Pastoral Care Services so as to facilitate communication with my clergy.

The following individual(s) are designated so that the hospital can share detailed healthcare information in an effort to make the best and most informed healthcare decisions with me:

_____
_____
_____

I understand that information concerning my treatment and condition during this admission is available to those involved with the provision of and payment for my care. Authorization is hereby granted to release information:

- ** To nursing homes, boarding facilities, congregate care facilities, home health care agencies to assess my discharge for appropriateness of the referral and for continuity of care by such facilities
- ** For purposes of conducting concurrent and retrospective on-site review and/or professional and utilization review and Quality Improvement Planning
- ** To physicians other than my attending physician to the extent that such information is needed in the professional judgement of SMRMC personnel or my attending physician in order to provide for my medical treatment.
- ** To other health care institutions, organizations, or facilities as necessary to continue my care or treatment at the direction of my physician

This authorization does not include review of diagnosis of HIV infection without specific written consent.

140209

FANTOZZI, Ronald Wood SMRMC 03/14/1999
MR#: 221342 ACCT#: 9073575 DOB: [redacted]/1962 IN: 2315 EXAM:

PROBLEM: Hand pain.

HPI: The patient is a 36-year-old male who, at 1700 hours this afternoon, when supinating his hand, had instant onset of sharp, tingling pain to his left hand radiating back toward his elbow. There is no trauma to the area. The pain has persisted despite his application of cold packs, and he presents now for pain relief.

PMH: Crohn's disease.

ALLERGY: No known allergies.
MEDS: OxyContin 40 mg p.o. b.i.d. and prednisone.
IMM:
PMD: Dr. Michael Boulanger.

EXAM: General appearance: The patient is a well-developed, well-nourished, white male who appears his stated age, in mild to moderate distress. Vital Signs: Temperature 37.0 p.o., pulse 92, respiratory rate 20, blood pressure 152/88.

EXTREMITIES: Exam is otherwise limited to the left hand, which shows swelling at the second MCP joint (index finger). The area is very tender to palpation. There is no fluctuation, consistent with abscess. There are no lacerations, hematoma or other obvious deformity. The patient does have range of motion at that joint, but it is restricted secondary to pain. The other MCP joints are normal. Distal circulation and sensation in all fingers, including the index finger, is intact. The patient has a strong radial pulse. The elbow is unremarkable.

COURSE/PROCEDURES:
X-RAY: Read by the Emergency Physician.
LEFT HAND (Plain films) No fracture or bony deformity, dislocation or other concerns.

The patient received a total of 100 mg of Demerol IM (in two aliquots) and 25 mg of Phenergan IM. He was placed in a hand splint to restrict motion of the MCP joint.

DX:
1. "Snapped" tendon.

MDM/TX/COUNSEL/COORD:
1. He is advised to continue to taking OxyContin for pain relief.
2. He is to followup with Dr. _____ at the Pain Control Clinic on Monday.

FANTOZZI, Ronald Wood SMRMC 03/14/1999
MR#: 221342 ACCT#: 9073575 DOB: [redacted]/1962 IN: 2315 EXAM:

NLM: (Continued)
3. He is to return to the emergency department for further concerns.

CONDITION AT DISCHARGE: Improved.

Douglas R. Wood, MD

DOD:03/15/1999 DRW/kjn
DOT:03/15/1999

ADDENDUM

Approximately two hours after the patient is discharged from the emergency department, he calls back and states that the pain in his hand is getting worse. When I asked him if he has taken any OxyContin for him, as I told him he should, he stated that he in fact had not and was hesitant to do so. I told him to go ahead and take the OxyContin and to wait at least one hour to ensure that he is getting maximal effect before either calling back or presenting to the emergency department.

Douglas R. Wood, MD

DOD:03/15/1999 DRW/kjn
DOT:03/15/1999

St. Mary's Regional Medical Center
Emergency Department Clinical Information
Campus Avenue
Lewiston, Maine 04240
Tel. (207) 777-8120

E2

2273575 MR 221342
ADM 5/14/9[redacted]
[illegible], RONALD M M
[illegible] POLAND RD
[illegible] ME 04210
0006605921-01
[redacted]/62 7823873

Patient's Name	ED Physician: DOC WOOD
Time Triage: 2315	Private Physician: BOULANGER
Presenting Complaint	
Pertinent Medical History / Reports None ☐ CHRONS	
Medications: Oxycontin BID, Prednisone,	
Triage Note: Acute onset @ ≈ 1700 of sharp, tingling pain to (L) hand when pt turned his hand over. Shower. Pain has persisted. Trials of cold & Δ. Vigorous capillary refill	

Mode of Arrival: ☐ Amb ☐ W/C ☐ Ambulance	
Immunizations UTD ☐ Yes ☐ No ☐ N/A	
Tetanus UTD ☐ Yes ☐ No ☐ N/A Date ____	
Allergies: NKDA.	
Developmental Age Per History Yes ☐ No ☐ N/A ☐	LMP N/A ☐
Weight ____ Kg N/A ☐	O_2 SAT ____ ON ____ N/A ☐

Time	BP	P	R	Temp
2315	152/88	92	20	37.2 po
Ortho-Statistics				

Triage RN: Dave Gunn RN

Mental Status	Skin	Pain N/A	Pupils (N/A)	Chest (N/A)	Abdomen (N/A)	Extremities N/A
☑ Awake	☐ Warm	☐ Absent	Perl Yes ☐ No ☐ N/A ☐	SOB Yes ☐ No ☐	☐ Soft	R L
☑ Alert	☑ Dry	☑ Present	Visual Acuity W/WO	Retractions Yes ☐ No ☐	☐ Non-Tender	☐ ☐ Pedal Pulses +
☑ Oriented	☐ Hot	Pain Scale	OD ____ OS ____	Stridor Yes ☐ No ☐	☐ Bowel Sounds +	☐ ☐ Pedal Pulse −
☐ Obeys Commands	☐ Flushed	☑ Rating 1-10 8	Size	R L	☐ Bowel Sounds −	☐ ☑ Edema
☐ Confused	☐ Pale		R ____ MM L ____ MM	☐ ☐ Clear	☐ Firm	☐ ☐ Deformity
☐ Unresponsive	☑ Cool	Cultural / Spiritual / Educational needs to be aware of		☐ ☐ Rales	☐ Tender	☐ ☑ Mobility Deficit
☐ Change in MS Yes ☐ No ☐	☐ Moist	Yes ☐ No ☐ N/A ☐		☐ ☐ Rhonchi	☐ Distended	☐ ☑ Sensation Deficit
	☐ Cyanotic			☐ ☐ Wheezes		
	☐ Jaundiced			☐ ☐ Decreased		

Time In Room	MD Notes	MD Orders	Tests
Time Seen By Physician	2320	Demerol 50 ✓ IM 2320/DGA	☐ CBC
		Phenergan 25	☐ LYT'S
			☐ BUN
		HAND SPLINT	☐ CREAT
			☐ BS
			☐ AMYLASE
			☐ ETOH
			☐ CCU SPEC
			☐ COAG
			☐ UA
			☐ C/S
			☐ SS
			☐ RED TOP HOLD
			☐ SMA 12
			☐ PURPLE TOP
	Continue Oxycontin		☐ EKG
	Splint for comfort		☐ ABG
	F/U c Snyder @ Hand Clinic		☐ HCG
	Mon		☑ X-RAY (L) HAND (DSW)
	0103	Caremap Yes ☐ No ☐	☐ Medical Record

Discharge Condition ☑ Improved ☐ Stable ☐ Unimproved ☐ Other ☐ Died

Provisional Diagnosis: SNAPPED TENDON

MD Signature: [signature]

500685.011.0109

St. Mary's Regional Medical Center
Emergency Department Clinical Information

Page 2

9073575 MR 221342
ADM 3/14/99
[redacted] ROMALD M
[redacted] POLAND RD
AUBURN ME 04210
MRN006605921-01
DOB [redacted]62 7023073

Vital Signs

Time	BP	P	R	T	O2SAT	Nursing Comments

Time	Nurses Treatments / Observations / Medications	Initials
2325	Demerol 50 & Phenergan 25 IM @ 2325	
0001	Demerol 50 IM @ 0001	

See Additional Notes ☐

				Total:		Total:		

IV D/C'D ☐ Yes ☐ No Site Healthy ____ Catheter Intact Upon D/C ____

Instructions / Education / RX: Discharge info & instructions. Home c wife driving

Time of Disposition or Death 0015

Disposition
☑ Home
☐ Admit to ____ Report To ____
☐ Transfer To ____

☐ Deceased ☐ Transfer Form Dates
☐ ME Notified
Organ Donation ☐ Yes ☐ No

Discharge Instructions Given ☑ Yes ☐ No | Verbalized Understanding ☑ Yes ☐ No | RN Signature [redacted]

500685.011.0110

St. Mary's Regional Medical Center
45 Golder Street, Lewiston, ME 04240 (207)777-8100
Aftercare Instructions

for Ronald Fantozzi, Monday, March 15, 1999, 12:08 am

IMPORTANT: We have examined and treated you today on an emergency basis only. This is not a substitute for, or an effort to provide, complete medical care. In most cases, you must let your doctor check you again. Tell your doctor about any new or lasting problems. It is impossible to recognize and treat all injuries or illnesses in a single Emergency Department visit. If you had special tests such as EKG's and X-rays, we will review them again within 24 hours. We will call you if there are any new suggestions. After leaving, you should **FOLLOW THE INSTRUCTIONS BELOW.**

You were treated today by Diane Wood, MD.

TENDINITIS.
Tendons are the "ropes" in the body that connect muscles to bones. They make our joints bend. They also help hold our joints together. Tendons, like ropes, are made of tiny fibers. If you overstretch or overuse them, they can get frayed. (Some of the tiny fibers can break.) Unlike the rope, though, a tendon can heal.

An injured tendon becomes "inflamed" or sore. That is called Tendinitis. Rest is the best treatment. Anti- inflammatory medicines can help, too. They cut down the body's reaction to the injury. The simplest and cheapest of these is aspirin. Many other medicines have been invented that may be stronger or have fewer side effects. It takes 2 to 3 weeks of treatment for tendonitis to get better.

Do the following:
- Rest your sore part for a week or so. Use it slowly after that.
- For first 1-2 days use cold packs for 15-20 minutes 4 times daily.
-- After 2 days use moist heat on same schedule.
- Wear splint for comfort.
- Keep hand elevated.
- Continue oxycontin as prescribed.

Call your doctor if you have:
- any new or severe symptoms.

****
THESE ARE YOUR FOLLOW-UP INSTRUCTIONS!
****
Call as soon as possible to make an appointment to see Dr. SNYDER MD in 24 hours. You can reach Dr. SNYDER MD at 783-2300, 12 High st, LEWISTON, ME 04240.
****

AS ALWAYS, YOU ARE THE MOST IMPORTANT FACTOR IN YOUR RECOVERY. Please follow the instructions above carefully. Take your medicines as prescribed. Most important, see a doctor again as discussed. If you have problems that we have not discussed, **CALL OR VISIT YOUR DOCTOR RIGHT AWAY.** If you can't reach your doctor, return to the Emergency Department.

"I understand the written and discussed instructions. My questions have been answered."

Ronald M Fantozzi
Patient or Responsible Person

Physician or Nurse

SEATBELTS. There is no doubt that seatbelts save lives. Every day in the Emergency Department we see how people without seatbelts are more severely hurt. We always buckle-up! Please do the same!

ST. MARY'S REGIONAL MEDICAL CENTER

Lewiston, ME 04240

RADIOLOGY REPORT

Name:	FANTOZZI, RONALD M
Pt. Phone:	782-3873
DOB:	[redacted]62
PHY(S):	MICHAEL BOULANGER, M.D.
PHY(S):	DOUGLAS R. WOOD, M.D.
Hosp #:	9073575
MR #:	22-13-42
X-RAY #:	08-99-89
Service Date:	03/14/99
NS/Room:	ER

LEFT HAND MULTIPLE VIEWS 73130

Indication for Study: Atraumatic left hand pain

FINDINGS: Examination of the left hand in multiple views show no evidence of fracture or dislocation. No lytic or blastic lesions are seen. The joint spaces are well maintained. Question of old avulsion injury of the ulnar styloid process is noted. The differential diagnosis includes accessory ossicle which is a normal variant. Clinical correlation is suggested.

IMPRESSIONS: Left hand, no evidence of acute abnormality.

TANWEER KHAN, M.D./reb

D: 03/15/99 T: 03/16/99

cc:

MICHAEL BOULANGER, M.D.	(F)
X-RAY BACK OFFICE	(O)
PHYSICIAN BILLING	(O)
RAD	(O)

ST. MARY'S REGIONAL MEDICAL CENTER

Lewiston, ME 04240

8278533 MS3 22-13-42

FANTOZZI, RONALD M
DOB: [redacted]/62

DISCHARGE SUMMARY
(Identification Sheet)
Page 1

Admitted: 10/05/98

Dictator: MICHAEL MONZEL, M.D.

DISCHARGE DATE: 10/09/98 **DEATH DATE:**

PROVISIONAL DX Crohn's disease with anastomotic involvement and partial small bowel obstruction now resolved and improved.

ALLERGIES, INC. DRUG REACTIONS

INFECTIONS & COMPLICATIONS

CONSULTATIONS

PRINCIPAL PROCEDURE (date) **SECONDARY PROCEDURE (date)**

PRINCIPAL DX
1. Crohn's disease with anastomotic involvement and partial small bowel obstruction now resolved and improved.

SECONDARY DX
2. Chronic severe pain related to Crohn's and possibly other factors.
3. History of renal calculi.
4. Status post previous ileal resection and right hemicolectomy for Crohn's.
5. Hepatitis-C with mildly active hepatitis, not treated.
6. Adjustment disorder with anxiety/panic attacks and probable depression.
7. Narcotic dependency.

ST. MARY'S REGIONAL MEDICAL CENTER

Lewiston, ME 04240

8278533 MS3 22-13-42

FANTOZZI, RONALD M
DOB: [redacted]62

DISCHARGE SUMMARY

Admitted: 10/05/98
Discharged: 10/09/98

Dictator: MICHAEL MONZEL, M.D.

HISTORY OF PRESENT ILLNESS: This 36-year-old male is admitted to the hospital with progressive severe right sided abdominal pain. The patient is seven years status post ileocolonic resection for recurrent pain. Recent workup because of ongoing pain and diarrhea has revealed recurrence at the anastomosis and ulcer and modest narrowing of the TI at this point. The patient also had a recent CT scan to further assess the severity of this pain which seemed to be out of proportion with objective findings and this was recently normal. He has also been treated recently for a renal calculi.

PHYSICAL EXAMINATION: The patient on examination was uncomfortable. His color was good. He is well nourished. The lung fields were clear. The abdomen was notable for nonsystemic tenderness on the right but it was relatively soft despite apparent appreciated severe tenderness. Bowel sounds were diminished. Rectal revealed no masses. Stool was Hemoccult negative.

LABORATORYDATA: Laboratory data revealed a white blood count of 11,300, hematocrit of 37, hemoglobin 13, MCV of 93. The platelet count was 285,000. Sodium was 139, potassium 3.6, chloride 104, CO2 of 29. The liver function tests were totally normal on admission and the amylase was normal. The urinalysis was negative.

A KUB and upright suggested early small bowel obstruction and dilated loops of small bowel.

HOSPITAL COURSE: The patient was admitted, kept NPO, given analgesics in the form of Demerol and pain improved minimally. Diarrhea increased in severity. He was begun on Solu-Medrol 100 mg IV q.12h. A stool for C-difficile toxin tidal returned positive. He was begun on Vancomycin and diarrhea slowly resolved. Despite the resolution of diarrhea and the fact that he was able to have a much softer abdomen and maintain oral intake, he continued to complain of pain. There was a concern of a secondary gain in depression behind this. He was seen on consultation by physiatry and psychiatry. The psychiatric evaluation did reveal that he was significantly depressed. He was begun on Luvox 50 mg p.o. b.i.d. while in the hospital and was switched over to Ativan. The patient was begun to be tapered off his pain medications. Physiatry consultation concurred with the psychiatric evaluation for pain management with medications and recommended outpatient referral to the Medical Rehabilitation Service. The patient is thinking about this at this point in time.

(SEE NEXT SHEET)

DISCHARGE PLAN: The patient was switched from Demerol to occasional oral Percocet. He seemed to be tolerate this switch well and will be discharged home on prednisone 30 mg p.o. q.d., Luvox 50 mg p.o. b.i.d., Percocet 1 tablet q.6h. only for severe pain, Vancomycin 125 mg p.o. q.i.d. for four more days and will be seen in followup from a gastrointestinal perspective in three weeks. He will followup with Dr. Boulanger to further assess issues of pain management also in the near future. He is to maintain a low-residual, relatively lactose-free diet.

MICHAEL MONZEL, M.D.

D: 10/09/98 MM
T: 10/15/98 pd

cc: MICHAEL MONZEL, M.D. (P)
MICHAEL BOULANGER, M.D. (F)
LUKE BALLENGER III, M.D. (P)
RONALD SNYDER, M.D. (P)
DEPT1 (P)

RB

ISSUE DATE: 10/13/98
ISSUE TIME: 13.33.25

ST. MARY'S
PHYSICIAN ATTESTATION REPORT

PGM-ID: BCM601

PATIENT NAME: FANTOZZI, RONALD M AGE: 36 Y SEX: M
ACCOUNT NUMBER: 8278533 ROOM: MS/0300 A
MEDICAL RECORD NUMBER: 221342 FIN. CLASS: C - COMMERCIAL
ADMISSION DATE: 10/05/98
DISCHARGE DATE/STATUS: 10/09/98 H - HOME

MDC/DRG ASSIGNMENT
06 - DISEASES & DISORDERS OF THE DIGESTIVE SYSTEM
180 - G.I. OBSTRUCTION W CC

PRINCIPAL DIAGNOSIS: 560.9 INTESTINAL OBSTRUCT NOS

SECONDARY DIAGNOSES

2.	008.45 INTESTINAL INF CLOSTRIDIUM	3.	555.0 REG ENTERITIS, SM INTEST
4.	296.32 RECURR DEPR -MOD	5.	300.21 AGORAPHOBIA WITH PANIC
6.	V13.01 PERS HX OF URINARY CALCULI	7.	V45.72 ACQ ABSENCE OF INTESTINE
8.	V02.62 HEPATITIS C CARRIER	9.	477.9 ALLERGIC RHINITIS NOS
10.		11.	
12.		13.	
14.		15.	

PRINCIPAL SURGEON:

PROCEDURES DATE PHYSICIAN

ATTENDING PHYSICIAN: 2589 MONZEL, MICHAEL J

500685.011.0116

ADMISSION RECORD

ST. MARY'S HOSPITAL
LEWISTON ME 04240

ADM. NO.	EC	ARRIVED	MED REC #	PATIENT NAME	SVC	NSTRUCT/BED	REG DTE
8278533	C	00221342		FANTOZZI, RONALD M	MED	MS 030 / B	10/05/98

PATIENT ADDRESS	AGE	D.O.B	PLACE OF BIRTH	SEX	MAR STA
40 POLAND RD	036Y	[redacted]/62	CT	M	M

CITY,STATE,ZIP	MAIDEN NAME	MOTHER/FATHER NAME
AUBURN ME 04210		

ATTENDING PHYSICIAN	NEXT OF KIN/SPOUSE	NEXT OF KIN/TELEPHONE NO
MONZEL, MICHAEL J	DEBORAH DEBORAH FA	T /

REFERRING PHYSICIAN	RACE/SMOKE	RECD FROM	DISCH	EMS NO
MONZEL, MICHAEL J	C / N	ER	8/17/98	

DATE/TIME ADMITTED	DATE/TIME DISCH/DEATH	ACCIDENT DATE/POOR
10/05/98 11:14	10/09/98 noon 2030	

PT. PHONE #	ADMIT BY	SOC SEC #	LOCATION	ADMITTING DIAGNOSIS
207 782-3873		096-54-2724		SMALL BOWEL OBST

EMPLOYER PHONE #	GUARANTOR (NAME/ADDRESS)	VETERAN	X-RAY NO
784-9186	40 POLAND RD AUBURN ME 04210		

ADVANCE DIRECTIVE

POWER OF ATTORNEY NONE LIVING WILL NONE

INSURANCE CO. NAME 410 3	POLICY NO.	GROUP NUMBER	SUBSCRIBERS NAME(S)	RELAT
HEALTHSOURCE ME	218103-01	999999	FANTOZZI, RONALD M	PT

ADMITTING DIAGNOSIS:
SMALL BOWEL OBSTRUCTION

COMMENTS	TRANS. OR ADMIT	DATE LAST SERV	PHYSICIAN
		8/17/98	02589

PATIENT INFORMATION

EMPLOYER NAME	EMPLOYER ADDRESS
FALCON	PO BOX 1286

CITY	STE	ZIP	PHONE NUMBER
Lewiston	ME	04243	(207) 784-9186

GUARANTOR INFORMATION

NAME		PAT. REL.	ADDRESS
FANTOZZI	RONALD M	PT	40 POLAND RD

CITY	STE	ZIP	PHONE NUMBER
AUBURN	ME	04210	(207) 782-3873

SOC.SEC. NO	EMPLOYER	ADDRESS
FALCON SHOE		CANAL ST

CITY	STE	ZIP	PHONE NUMBER
LEWISTON	ME	04240	(207)

SUBSCRIBER INFORMATION

NAME		SEX	PAT.REL	ADDRESS
FANTOZZI	RONALD M	M	PT	40 POLAND RD

CITY	STE	ZIP	PHONE NUMBER
AUBURN	ME	04210	(207) 782-3873

1ST INSURANCE CO. NAME	ADDRESS	CITY	STATE	ZIP
HEALTHSOURCE ME	174 FREEPORT ROAD	FREEPORT	ME	04032

NAME		SEX	PAT.REL	ADDRESS

CITY	STE	ZIP	PHONE NUMBER
		00000	(000)

2ND INSURANCE CO. NAME	ADDRESS	CITY	STATE	ZIP

500685.011.0117

St. Mary's Regional Medical Center

8078533

Consent/Assignment/Authorization Statement

Consent for Treatment Admission Date: 10/5/98 Fantozzi Ronald

I, the undersigned a patient in this St. Mary's Regional Medical Center ("SMRMC"), hereby authorize employees of SMRMC and physician(s) (and whomever they may designate as assistants) to administer such treatment as is necessary, and such additional operations or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment. I also consent to the administration of such anesthetics as are necessary. Any tissues or parts surgically removed may be disposed of by SMRMC in accordance with accustomed practice. I hereby certify that I have read and fully understand the above Consent for Treatment: the reasons why the treatment/procedure is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment which have been explained to me by the attending physician. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Authorization To Release Medical Information

St. Mary's Regional Medical Center is hereby authorized and requested to furnish the Health Source insurance company(s) or its properly authorized agent, my employer and any peer review organization which conducts reviews of hospital utilization under an agreement with my employer and/or health insurance carrier, or any person or corporation that is or may be liable, under contract or otherwise, for all or part of the Medical Center's charge; all information required by it to determine benefits, including nature of the visit, diagnostic and treatment information, and copies of my medical record which may be available to said hospital.

Assignment Of Benefits

I hereby assign unto St. Mary's Regional Medical Center and related contracted professionals, all hospital insurance benefits now due and to become due and payable to me or on my behalf, but not to exceed the Medical Center's charges by virtue of my treatment by the hospital, and I hereby direct the Health Source Insurance Company(s) to pay such benefits directly to the hospital in consideration of the hospital care and services furnished and to be furnished by the hospital.

Payment Terms

I understand payment of charges are due for services rendered within Thirty (30) days including any collection or attorney's fees. If I am financially unable to do so, I agree to complete a detailed financial statement so alternative payment arrangements can be determined. I agree to pay all charges for services not authorized for payment by any Health Maintenance Organization, Preferred Provider Organization or other Managed Care Organization for which I seek certification for treatment by St. Mary's.

Release From Responsibility For Personal Property

I understand and agree that under no circumstances will St. Mary's Regional Medical Center be responsible for my personal property. I take full responsibility for retaining in my possession or custody any and all articles. I acknowledge that I have declared or listed all items of personal property I have chosen to keep in my possession or custody while at St. Mary's, and further acknowledge that I have been offered an opportunity to have my personal property kept at St. Mary's during my stay at St. Mary's, and that I have refused that offer.

Authorization For Payment Of Medical Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or any other medical insurers, any information needed for this or a related Medicare, or other medical insurance claim. I request that payment of authorization of authorized benefits be made to St. Mary's Regional Medical Center and to physicians or organizations providing medical services to me or for my benefit. For extended outpatient services I request this authorization apply to the extent of my services.

An Important Message From Medicare/Champus

I certify that I have received the Medicare Bill of Rights entitled "An Important Message From Medicare/Champus". Acknowledgement of receipt of this message does not waive any of my rights to request a review or make me liable for payment.

I Have Read This Consent/Authorization Completely And Crossed Out Any Words Or Phrases That I Do Not Accept:

Ronald Fantozzi	10.5.98	
Patient Signature:	Date	Time
Debra Fantozzi	10.5.98	
Guarantor Signature	Date	Relationship
M Lundgren	10/5/98	
Witness Signature	Date	

Telephone Consent Received By: _____ Date: _____ Time: _____

140209

500685.011.0118

EMERGENCY DEPARTMENT REPORT

St. Mary's REGIONAL MEDICAL CENTER

ADMIT NO	F.C.	HOW ARRIVED	MED. REC. NO	PATIENT NAME	SERVICE	NUR. STA	ROOM-BED	
8278533	C	WC	00221342	FANTOZZI, RONALD M	EMC			10/05/98

PATIENT ADDRESS	AGE	DATE OF BIRTH	PLACE OF BIRTH	SEX	MAR. STATUS
40 POLAND RD	036Y	[redacted]/62	CT	M	M

CITY, STATE, ZIP	MAIDEN NAME	MOTHER/FATHER NAME
AUBURN ME04210		

ATTENDING PHYSICIAN	NEXT OF KIN/SPOUSE	NAME AT LAST ADMIT	VETERAN
FLANAGAN, TERRENCE	DEBORAH		

PRIVATE PHYSICIAN	RACE/ORIGIN	RELIGION	PREV. DISCH. DATE	EMS. NO
MONZEL, MICHAEL J		C		

DATE AND TIME OF SERVICE	ACCIDENT DATE/HOUR	DATE AND TIME OF DEATH
10/05/98 8:16	10/04/98 8:00	

INSURANCE CO. NAME	POLICY NO.	GROUP NUMBER	SUBSCRIBER'S NAME(S)	RELAT
410 REALTRSOURCE ME	218103-01	999999	FANTOZZI, RONALD M	PT

PT. PHONE # 207 782-3873 NEXT OF KIN PHONE # 207 782-3873 SOC. SEC. # 006542772

PATIENT'S COMPLAINT: RECHECK/CROHNS DESEASE

DIAGNOSIS: Crohns

ALLERGIES: NKA

LAST TETANUS:

TRIAGE: To see Dr Monzel - Seen in ED this night - returns for continued pain

See cont sheet

			PPD	
0830	37.3	80	18	118/80

MEDICATIONS: Lucex

TRIAGE SIGNATURE: [signature]

- ☑ CBC done
- ☑ LYTES
- ☐ BUN
- ☐ BS
- ☐ AMYLASE
- ☐ ETOH
- ☐ CCU SPEC.
- ☐ COAG
- ☑ UA DC
- ☐ CS
- ☐ SS
- ☐ RED TOP HOLD
- ☐ SMA 12
- ☐ EKG
- ☐ ABG
- ☐ HCG
- ☑ X-RAY Obst. Series
- ☐ IV - Demerol
- ☑ Demerol 50mg IM
- ☑ Phenergan 25mg IM
- Dilaudid 2mg

TX/PROCEDURE:

DISCHARGE DISPOSITION: Adm + D3

0168

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
	[signature]		[signature]		

DATE / TIME 11:30

MEDICAL RECORDS

500685.011.0119

☐ PATIENT CALLED WITH LABORATORY / X-RAY RESULTS: _____ DATE _____ TIME _____ INITIALS

St. Mary's Regional Medical Center
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X Debra Fantozzi Patient Signature:	10-5-98 Date	8:20 Time
X Debra Fantozzi Guarantor Signature	10-5-98 Date	Wife Relationship
X Sandra Pawlak Witness Signature	10-5-98 Date	

Telephone Consent Received By: _____ Date: _____ Time: _____